(4.) A delivery incentive shall be paid to approved providers offering delivery to all Medicaid recipients requesting it. The delivery service is considered part of the Medicaid benefit, and as such, an approved provider receiving the delivery incentive must accept Medicaid payment as payment in full. The delivery incentive is $0.15 per prescription and is to be paid on all Medicaid prescriptions filled. This delivery incentive is not to be paid for over-the-counter drugs which are prescribed as a benefit of this program.

C. Estimated Acquisition Cost

For all medications, legend and non-legend, covered by the Vendor Drug Program and appearing in the Texas Drug Code Index (TDCI) and updates, the following requirements must be met.

(1.) Reimbursement to the pharmaceutical provider is based on the department's best estimate of acquisition cost (EAC), verifiable by invoice audit, plus the department's currently established dispensing fee, or the usual and customary price charged the general public, whichever is lower.

(2.) Estimated acquisition cost is defined as wholesale estimated acquisition cost (WEAC) or direct estimated acquisition cost (DEAC), according to the pharmacist's usual purchasing source and the pharmacist's usual purchasing quantity, or as a maximum allowable cost (MAC) for multi- source products. All drug purchases from a central purchasing entity must be billed to the department as warehouse purchases. The WEAC is established by the department using the current *Redbook, Redbook* update, First Databank or manufacturer pricing less a discount of 15%, which represents discounts received by pharmacists on wholesale drug purchases. The WEAC may not exceed wholesaler cost, as supplied by the drug manufacturers, plus a 12% markup representing wholesaler operating costs and profits. Exceptions to the percentages may be made on certain drugs and/or drug categories where additional information supplied to the department by the manufacturer indicates that application of the specific WEAC percentages does not reflect customarily available prices. The DEAC is established by the department using direct price information supplied by drug manufacturers. Providers are reimbursed only at the DEAC on all drug products that are available from select manufacturers/distributors who actively seek and encourage direct purchasing. The TDCI is used as the reference for drugs included in the scope of benefits and for allowable package sizes. No acquisition cost is billed to the department for samples dispensed.

(3.) Reimbursement for non-legend drugs is based on the usual and customary price charged to the general public or EAC, plus 50% of the EAC, whichever is lower. No dispensing fee is added to the price of non-legend drugs, and 50% of the EAC may not exceed the assigned dispensing fee.

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D. Texas Maximum Allowable Cost

Multisource drugs included in the Vendor Drug Program's formulary, the Texas Drug Code Index (TDCI), are subject to Texas maximum allowable cost (TMAC) reimbursement limits. Multisource drugs are sorted into therapeutic categories based on the drug and strength, and in some cases, on the dosage form and package size. Drug products exempt from the drug substitution provisions of the Texas Pharmacy Act and drug products that the Federal Food and Drug Administration does not consider to be therapeutically equivalent to other pharmaceutically equivalent products are exempt from TMAC reimbursement limits. The department may choose to exempt other multisource drug categories from TMAC reimbursement limits.

The TMAC reimbursement limit selected for each therapeutic category is determined using the wholesale estimated acquisition cost (WEAC) of all drugs in the respective category. When a multisource drug is not available through a bona fide full-service drug wholesaler or is reimbursable only on a DEAC basis, as defined by the department, then the direct estimated acquisition cost (DEAC) of the drug is included in the calculation of the TMAC reimbursement limit. The department retains the right to adjust the reimbursement limit in any category or on an individual basis.

The TMAC reimbursement limits are maximum reimbursement limits. If a pharmacy provider dispenses a drug with a WEAC or DEAC below the TMAC limit, reimbursement is made at the lower cost based on the provider's source of purchase of the drug. If a drug is subject to both TMAC limits and federal maximum allowable cost limits, the lower of the two limits is the maximum reimbursement limit.

A pharmacy provider that dispenses a drug that is subject to a TMAC limit and bills the department for the services must accept Medicaid reimbursement as payment in full. No additional dispensing fee or product cost amount may be billed to Medicaid recipient.

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8. Payment for authorized home health care services furnished to eligible recipients by approved home health agencies is made in accordance with the ~~same methods~~ and procedures used under Medicare ~~(Title~~ XVIII of the Social Security Act) for comparable ~~home~~ health care services.

Supersedes Eff 1 part 3a, 07 TN 79-

9. Subject to the specifications, conditions, and limitations established by the Single State Agency, payment for authorized hearing evaluations, hearing aids and repairs, when provided to an individual eligible for such services by an approved provider, will be made by the Single State Agency directly or by contract or other arrangement according to fee schedules established by the Single State Agency. Such fee schedules were developed after consideration of such factors as invoice costs for hearing aids, and where appropriate, evaluation, fitting, dispensing and follow-up fees. The fee schedules are designed to assure that payments will not exceed the upper limits of the provider's customary charges or the prevailing charges in a locality for comparable benefits under comparable circumstances. Payment will not be made to institutions or medical facilities when such services or supplies are included in the reimbursement formula and the vendor payment to the institution.

Payment for examinations provided by physicians licensed to practice medicine in Texas will be made on the same basis as provided elsewhere in this State Plan for "physicians' services".

10. Subject to the specifications, conditions, and limitations established by the Single State Agency and in accordance with the contracts between the Single State Agency and its health insuring agent, payment for authorized eyeglass benefits, when provided to an eligible recipient by an approved provider, will be made on the basis of fee schedules established by the Single State Agency. Such fee schedules were developed after consideration of such factors as invoice costs for supplies, handling fees and, where appropriate, dispensing fees. The fee schedules are designed to assure that payments will not exceed the upper limits of the provider's customary or the prevailing charges in a locality for comparable benefits under comparable circumstances.

This does not involve the diagnostic, treatment or other professional services, including aphakic benefits, or the basis of payment for these services which are contained elsewhere in this State Plan.

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8. Reimbursement Methodology for Home Health Services.

(a) Reimbursement methodology for services provided by a home health agency.

(1) Except for expendable medical supplies and DME, authorized home health services provided for eligible Medicaid recipients are reimbursed the reasonable cost of supplying the service, applying the same standards, cost reporting period, and cost reimbursement principles currently used in computing reimbursement for comparable services under Title XVIII Medicare.

(2) Reasonable cost will be based on annual reports covering a 12-month period of operation (based on a provider's reporting year) required by Medicare.

(b) Reimbursement methodology for expendable medical supplies provided by enrolled home health agencies and DME providers /suppliers. Participating providers are reimbursed the maximum allowable fee for expendable medical supplies established by the single state agency. The maximum allowable fee is based upon the lesser of the following:

(1) billed amount

(2) the Medicare fee schedule

(3) the expendable medical supply acquisition fee as determined by the single state agency by periodic sampling of suppliers or from information provided in manufacturer's publications, whichever is lesser.

(c) Reimbursement methodology for durable medical equipment provided by enrolled home health agencies and DME providers/suppliers. Participating providers are reimbursed the maximum allowable fee for durable medical equipment established by the the single state agency. The maximum allowable fee for durable medical equipment is based on the lesser of the following:

(1) the billed amount;

(2) the durable medical equipment acquisition fee, which is based upon the manufacturer's suggested retail price minus a discount;

(A) the manufacturer's suggested retail price is the listed price that the manufacturer recommends as the retail selling price;

(B) the discount from the manufacturer's suggested retail price is determined from the total discount that vendors receive from manufacturers. The initial value of the discount shall be 18%. Therefore, the single state agency is responsible for periodically conducting a representative sample by which a discount is determined. Participating providers must, upon written request, provide necessary information needed to determine the discount. The discount shall be reviewed at least every five years. If no discount is provided, the incurred cost to the dealer plus a percentage to be determined by the single state agency.

(3) the Medicare fee schedule

SUPERSEDES: TN. 94-17

Exception: Payment for insulin syringes and needles obtained by a physician's prescription from a participating pharmacy will be made in accordance with the reimbursement methodology outlined in ~~Attachment 4.19-B, Item H, pages 2j and 2k.~~

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12. Payment for authorized medical transportation furnished to eligible recipients as a Title XIX benefit by approved transportation providers both private and public will be based on a negotiated reasonable charge per trip adjusted to reflect a round trip in cases where assurance contracts are the best method to reduce costs. In payment-per-trip contracts, payment will be based on reasonable charges not to exceed the rates established by the Single State Agency. Transportation and reimbursement, therefor, under this plan are assistance expenditures and will not exceed the upper limits contained in 45 CFR 250.30.

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13. Subject to the specifications, conditions and limitations established by the State agency and in accordance with the contract between the State agency and the rural health clinic:

A. Payment for authorized, medically necessary rural health clinic services as defined at 42 CFR 449.10(b)(2)(ii), when provided to an eligible recipient by a certified and approved rural health clinic, will be made on the basis of the principles specified in 42 CFR 450.30(a)(10)(i) and (ii).

B. Payment for other ambulatory services which are covered under this State plan and which are apart from and other than rural health clinic services defined at 42 CFR 449.10(b)(2)(ii) when provided to an eligible recipient by a certified and approved rural health clinic, will be made at rates or charges established under this State plan for payment to providers of these services other than a rural health clinic. Payment for other ambulatory services is subject to the upper limits specified in 42 CFR 450.30.

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14. REIMBURSEMENT METHODOLOGY FOR PRIMARY HOME CARE SERVICES

I. General. The Texas Department of Human Services (DHS) reimburses Primary Home Care (PHC) providers for services provided to eligible recipients. A prospective, uniform statewide reimbursement is determined for each Primary Home Care service. Reimbursements are reviewed periodically and revised as appropriate.

II. Cost data. In order to ensure adequate financial and statistical information upon which to base reimbursement, DHS collects cost data at least annually. It is the responsibility of the provider to submit accurate and complete information, in accordance with all pertinent DHS rules and instructions.

III. Audits and desk reviews. DHS conducts desk reviews and field audits of provider cost reports in order to ensure that all financial and statistical information reported in the cost reports conforms to all applicable rules and instructions. A contracted provider may request an informal review, and subsequently an appeal, of a desk review or field audit disallowance.

IV. Inflation. In order to account for cost inflation between the reporting period and the prospective reimbursement period, DHS makes adjustments to allowable costs based on inflation factors or multipliers calculated from appropriate inflation indices.

(A) Contracting for inflation index development. DHS may contract with a reputable and experienced independent professional firm to develop appropriate optional indices for Texas. If DHS obtains such indices under contract, the agency retains the option, on a program by program basis, of utilizing these indices and/or those described in the remainder of this section, either separately or in combination, for reimbursement determination purposes.

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(B) Cost inflation indices. DHS may utilize a general cost inflation index obtained from a reputable independent professional source and, where DHS deems appropriate and pertinent data are available, develop and/or utilize several item-specific and program-specific inflation indices, as follows.

(1) General cost inflation index. DHS uses the Implicit Price Deflator-Personal Consumption Expenditures (IPD-PCE) as the general cost inflation index. The IPD-PCE is a nationally recognized measure of inflation published by the Bureau of Economic Analysis of the U.S. Department of Commerce. To project or inflate costs from the reporting period to the prospective reimbursement period, DHS uses the lowest feasible IPD-PCE forecast consistent with the forecasts of nationally recognized sources available to DHS at the time proposed reimbursement is prepared for public dissemination and comment.

(2) Item-specific and program-specific inflation indices. DHS may use specific indices in place of the general cost inflation index when appropriate item-specific or program-specific cost indices are available from DHS cost reports or other surveys, other Texas state agencies or independent private sources, or nationally recognized public agencies or independent private firms, and DHS has determined that these specific indices are derived from information that adequately represents the program(s) or cost(s) to which the specific index is to be applied. For example, DHS may use specific indices pertaining to cost items such as payroll taxes, key professional and non-professional staff wages, and other costs subject to specific federal or state limits.

V. Reimbursement determination. DHS determines reimbursement in the following manner.

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(A) Cost determination by cost area. DHS combines reported allowable costs into five cost areas, after allocating payroll taxes to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense and after applying employee benefits directly to the corresponding salary line item.

(1) Field supervisors cost area. This includes field supervisors' salaries, wages, training, travel expenses and other expenses. These costs are divided by total hours of service, including total nonpriority and Priority 1 service hours, in order to calculate each provider's field supervisor unit cost.

(2) Nonpriority attendants cost area. This includes nonpriority attendants' salaries and wages, training, travel and other expenses. These costs are divided by total nonpriority hours of service in order to calculate each provider's nonpriority attendant unit cost.

(3) Administration cost area. This includes administrative salaries and wages, and other administrative expenses. These costs are allocated between nonpriority and Priority 1 services. Administration expenses equal to $0.18 per Priority 1 hour of service are allocated to Priority 1. To calculate the administration unit cost, the remaining non-allocated administration costs are divided by total nonpriority and Priority 1 hours of service. For nonpriority, the calculated administration unit cost is the nonpriority administration unit cost. For Priority 1, the $0.18 is added to the calculated administration unit cost to determine the Priority 1 administration unit cost.

(4) Facility cost area. This includes building and equipment expenses, and operation and maintenance expenses. These costs are divided by total hours

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of service, including nonpriority services and Priority 1 services, in order to calculate each provider's facility unit cost.

(5) Priority 1 attendants cost area. This includes Priority 1 attendants' salaries and wages, training, travel and other expenses. These costs are divided by total Priority 1 hours of service in order to calculate each provider's Priority 1 attendant unit cost.

(B) Projected costs. DHS projects allowable expenses, excluding depreciation and mortgage interest, per hour of service from each provider agency's reporting period to the next ensuing reimbursement period. DHS uses appropriate inflation indices as described in section 14. IV., Inflation, of this attachment.

(C) Projected cost arrays. To calculate reimbursement per hour of service, DHS rank-orders from low to high all provider agencies' projected allowable costs per hour of service in each cost area.

(D) Recommended reimbursement for each cost area component. The hours of service used to calculate each cost area component for each provider agency are summed until the median hour of service is reached. The corresponding projected expense is the weighted median cost component. The cost component for each cost area is multiplied by 1.044 to calculate the recommended reimbursement for each cost area component.

(E) Total recommended reimbursement.

(1) For nonpriority clients. DHS determines the recommended reimbursement by summing the recommended reimbursement described in paragraph (D) of this subsection for the cost area components described in paragraph (A)(1)-(4) of this subsection.

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